

SCOPE OF SALES APPOINTMENT CONFIRMATION FORM



The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. Please initial below beside the type of product(s) you want the agent to discuss.

MEDICARE ADVANTAGE PLANS (PART C) AND COST PLANS

_____ Medicare Health Maintenance Organization (HMO)

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

_____ Medicare Preferred Provider Organization (PPO) Plan

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors and hospitals, but you can also use out-of-network providers, usually at a higher cost.

_____ Medicare Point of Service (POS) Plan

A type of Medicare Advantage Plan available in a local or regional area which combines the best feature of an HMO with an out-of-network benefit. Like the HMO, members are required to designate an in-network physician to be the primary health care provider. You can use doctors, hospitals, and providers outside of the network for an additional cost.

_____ Medicare Special Needs Plan (SNP)

A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.



Effective Date: _____

Section 1

All fields on this page are required (unless marked optional)

SELECT THE PLAN YOU WANT TO JOIN:

ARIZONA

<input type="checkbox"/> H3443-001	Alignment Health the ONE + Walgreens (HMO)	\$0 per month	Maricopa
<input type="checkbox"/> H3443-002	Alignment Health the ONE + Walgreens (HMO)	\$0 per month	Pima, Santa Cruz
<input type="checkbox"/> H3443-005	Alignment Health smartHMO	\$0 per month	Maricopa, Pima, Santa Cruz
<input type="checkbox"/> H3443-005	Complete Package (Optional Buy Up)	\$64.90 per month	Maricopa, Pima, Santa Cruz

CALIFORNIA (HMO)

<input type="checkbox"/> H3815-001	Alignment Health My Choice (HMO)	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino
<input type="checkbox"/> H3815-008	Alignment Health Platinum + Instacart (HMO)	\$0 per month	Los Angeles, Orange
<input type="checkbox"/> H3815-011	Alignment Health AllCare Preferred (HMO)	\$0 per month	Stanislaus
<input type="checkbox"/> H3813-013	Alignment Health smartHMO	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
<input type="checkbox"/> H3815-016	Alignment Health Platinum + Instacart (HMO-POS)	\$0 per month	Marin, San Diego, San Francisco
<input type="checkbox"/> H3815-019	Alignment Health Sutter Advantage +More (HMO)	\$19 per month	Placer, Sacramento, Yolo
<input type="checkbox"/> H3815-020	Alignment Health Sutter Advantage +More (HMO)	\$49 per month	Santa Clara
<input type="checkbox"/> H3815-021	Alignment Health Sutter Advantage +More (HMO)	\$59 per month	Santa Cruz
<input type="checkbox"/> H3815-023	Alignment Health Sutter Advantage +More (HMO)	\$48 per month	San Francisco, San Mateo, Sonoma
<input type="checkbox"/> H3815-028	Alignment Health My Choice (HMO)	\$0 per month	San Luis Obispo, Ventura
<input type="checkbox"/> H3815-031	Alignment Health Harmony (HMO)	\$0 per month	Alameda, San Francisco, Santa Clara, San Mateo
<input type="checkbox"/> H3815-034	Alignment Health the ONE (HMO)	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara
<input type="checkbox"/> H3815-035	Alignment Health the ONE + Walgreens (HMO)	\$0 per month	Fresno, Madera, Merced
<input type="checkbox"/> H3815-038	Alignment Health smartHMO	\$0 per month	Placer, Sacramento, Yolo
<input type="checkbox"/> H3815-040	Alignment Health smartHMO	\$0 per month	Merced, Santa Clara, Stanislaus, Ventura
<input type="checkbox"/> H3815-046	Alignment Health Community (HMO)	\$0 per month	Fresno, Madera
<input type="checkbox"/> H3815-047	Alignment Health smartSavings (HMO)	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
<input type="checkbox"/> H3815-049	Alignment Health My Choice Select (HMO)	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino
<input type="checkbox"/> H3815-050	Alignment Health My Choice CalCare (HMO)	\$0 per month	Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Clara, Stanislaus, Ventura, Yolo
<input type="checkbox"/> H3815-052	Alignment Health Honor+ Plan (HMO)	\$0 per month	Alameda, Fresno, Los Angeles, Madera, Marin, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Stanislaus, Ventura, Yolo
<input type="checkbox"/> H3815-053	Alignment Health ValorCare (HMO)	\$0 per month	Los Angeles, Orange, Riverside, San Bernardino, San Diego
<input type="checkbox"/> H3815-055	Alignment Health L.A. Premium Giveback (HMO)	\$0 per month	Los Angeles
<input type="checkbox"/> H3815-056	Alignment Health S.D. Premium Giveback (HMO)	\$0 per month	San Diego
<input type="checkbox"/> H3815-001, -008, -011, 019, -020, -021, 023, -028, -031, 034, -035	Enhanced Dental Option (Optional Buy Up)	\$36 per month	Alameda, Fresno, Los Angeles, Madera, Merced, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, Yolo



First Name: <input type="text"/>		Last Name: <input type="text"/>		Middle Initial (optional): <input type="text"/>
Birth Date: (MM/DD/YYYY) <input type="text"/>		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: <input type="text"/>	
Email Address: <input type="text"/>		Cell Phone Number (Optional): <input type="text"/>		
Permanent Residence Street Address (Don't Enter a P.O. Box): <input type="text"/>				
City: <input type="text"/>		County (Optional): <input type="text"/>		State: <input type="text"/> ZIP Code: <input type="text"/>
Mailing Address, If Different From Your Permanent Address (P.O. Box Allowed): <input type="text"/>				
City: <input type="text"/>		County (Optional): <input type="text"/>		State: <input type="text"/> ZIP Code: <input type="text"/>
Emergency Contact (Optional): <input type="text"/>		Relationship: <input type="text"/>	Phone Number: <input type="text"/>	
YOUR MEDICARE INFORMATION:				
Medicare Number: <input type="text"/>				
Answer these important questions:				
Will you have other prescription drug coverage (like VA, TRICARE) in addition to Alignment Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of Other Coverage: <input type="text"/>		Member Number for this Coverage: <input type="text"/>		Group Number for this Coverage: <input type="text"/>
Please choose the name of a primary care provider (PCP). For HMO plans, if the PCP you choose is not available, an available PCP will be automatically assigned to you.				
Primary Care Provider: <input type="text"/>		Primary Care Provider ID: <input type="text"/>		Medical Group: <input type="text"/>
I am a(n) <input type="checkbox"/> Existing Patient <input type="checkbox"/> New Patient				
Are you eligible or enrolled in a State Medicaid or Medi-Cal program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you are enrolled in a State Medicaid Program				
Medicaid number: <input type="text"/>				
IMPORTANT: READ AND SIGN BELOW:				
<ul style="list-style-type: none"> • I must keep both Hospital (Part A) and Medical (Part B) to stay in Alignment Health Plan. • By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Alignment Health Plan will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan. I understand that I can be enrolled in only one MA plan at a time - and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFTS, and MA MSA plans). • I understand that when my Alignment Health Plan coverage begins, I must get all of my medical and prescription drug benefits from Alignment Health Plan. Benefits and services provided by Alignment Health Plan and contained in my Alignment Health Plan "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Alignment Health Plan will pay for benefits or services that are not covered. • The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that: <ol style="list-style-type: none"> 1. This person is authorized under State law to complete this enrollment, and 2. Documentation of this authority is available upon request by Medicare. 				
Signature: <input type="text"/>		Today's Date: <input type="text"/>		
If you're the authorized representative, sign above and fill out these fields:				
Name: <input type="text"/>		Address: <input type="text"/>		
Phone Number: <input type="text"/>		Relationship to Enrollee: <input type="text"/>		



Section 2**All fields on this page are optional****ANSWERING THESE QUESTIONS IS YOUR CHOICE. YOU CAN'T BE DENIED COVERAGE BECAUSE YOU DON'T FILL THEM OUT.**

Select one if you want us to send you information in a language other than English.

 Spanish Vietnamese Chinese Korean Other

Select one if you want us to send you information in an accessible format. Standard/Regular Font Braille Large Print Audio Data CD
 Please contact Alignment Health Plan at 1-866-634-2247 (TTY 711) if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., 7 days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. If no selection is made, Standard/Regular font will be sent.

Do you work? Yes NoDoes your spouse work? Yes No

The following materials will be sent to you via email unless you prefer to receive a printed copy. Please check below if you prefer to receive a printed version.

 Part C Explanation of Benefits (EOB) Part D Explanation of Benefits (EOB) Annual Notification of Change (ANOC)**Paying your plan premiums**

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail each month.

You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

Please select a plan premium and/or late enrollment payment option:

 Get a bill

Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Alignment Health Plan the Part D-IRMAA.

Sales Representative (if assisted with Enrollment):

Enrolling Sales Representative's Signature:

Print Name: Phone Number: () - NPN#: Sales ID#: Date: / / **For Office Use Only:**

AHC-ENR-HMO/PPO-2026-5

PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60 authorize the collection of this information. CMS may use, disclose, and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Alignment Health Plan is an HMO, HMO-PDS, HMO C-SNP, HMO D-SNP, and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTESTATION OF ELIGIBILITY FOR AN ENROLLMENT PERIOD



Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan or I recently moved, and this plan is a new option for me. I moved on (insert date) / / .
- I was recently released from incarceration. I was released on (insert date) / / .
- I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) / / .
- I recently obtained lawful presence status in the United States. I got this status on (insert date) / / .
- I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) / / .
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) / / .
- I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but haven't had a change.
- I am moving into, live in, or recently moved out of a Long-Term Care facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) / / .
- I recently left a PACE program on (insert date) / / .
- I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) / / .
- I am leaving employer or union coverage on (insert date) / / .
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date) / / .
- I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) / / .
- I was affected by a weather-related emergency or major disaster, as declared by the Federal Emergency Management Agency (F.E.M.A.). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Alignment Health Plan at 866-634-2247 (TTY 711), 8am-8pm, seven days a week (except Thanksgiving and Christmas) from October 1 to March 31 and 8am-8pm Monday through Friday (except holidays) from April 1 through September 30, to see if you are eligible to enroll. Alignment Health Plan is an HMO, HMO-POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina, and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

2026 Attestation of Enrollment

